

11-30-1997

# DDASaccident137

Humanitarian Demining Accident and Incident Database  
*AID*

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# DDAS Accident Report

## Accident details

<b>Report date:</b> 15/05/2006	<b>Accident number:</b> 137
<b>Accident time:</b> not recorded	<b>Accident Date:</b> 30/11/1997
<b>Where it occurred:</b> Mahal-I-Wardak Village, Enjil District, Herat Province	<b>Country:</b> Afghanistan
<b>Primary cause:</b> Management/control inadequacy (?)	<b>Secondary cause:</b> Management/control inadequacy (?)
<b>Class:</b> Missed-mine accident	<b>Date of main report:</b> [No date recorded]
<b>ID original source:</b> none	<b>Name of source:</b> MAPA/UNOCHA
<b>Organisation:</b> Name removed	
<b>Mine/device:</b> M-19 AT blast	<b>Ground condition:</b> route/path wet
<b>Date record created:</b> 13/02/2004	<b>Date last modified:</b> 13/02/2004
<b>No of victims:</b> 4	<b>No of documents:</b> 1

## Map details

<b>Longitude:</b>	<b>Latitude:</b>
<b>Alt. coord. system:</b>	<b>Coordinates fixed by:</b>
<b>Map east:</b>	<b>Map north:</b>
<b>Map scale:</b> not recorded	<b>Map series:</b>
<b>Map edition:</b>	<b>Map sheet:</b>
<b>Map name:</b>	

## Accident Notes

inadequate investigation (?)  
inconsistent statements (?)  
mine/device found in "cleared" area (?)  
inadequate area marking (?)

## Accident report

An investigation on behalf of the UN MAC was carried out and its report made briefly available. The following summarises its content.

Victim No.1 had two years experience. Victim No.2 had two years experience. Victim No.3 had five years experience. Victim No.4 had four years experience. All victims had attended a

revision course six days before. All victims had last been on leave 34 days before. The Team Leader also reported that a dog got a fractured foot in the accident [there is no other mention of this]. The investigators claim to have found fragments of the mine from which to identify it as an M-19 AT blast mine.

The victims were in a vehicle that detonated an AT mine with a front wheel. The ground was a dirt road in grazing land. A photograph showed a flat earth area with water in puddles. "The front wheel of the truck and the cabin were destroyed". [A photograph showed the cab separated from the truck and severely damaged.]

The investigators decided that the group did not check the parking and access areas they were using while working. They inadvertently placed their access route inside another minefield (surveyed in 1995 but the markings had become invisible). They used the parking area for 59 days. On the 60<sup>th</sup> day they were parking when the mine was initiated.

**The Team Leader** said the accident occurred when parking and was only preventable if the mine had not been placed.

**The Sub-Commander** said that the responsible body only told them that the parking area was a cleared minefield after the accident occurred. He thought that their briefing was defective because it did not consider access. The signs left by a previous survey had gone, and the surveyed maps were distributed without an organised plan.

**A witness deminer** said that one dog handler was getting out of the truck when the accident occurred.

**One victim** said he could remember nothing of the accident. He said they had parked in the same place for 59 days so thought the mine had been buried recently.

**Another victim** said that the mine must have been placed "for us". He claimed they had checked the area before using it.

## Conclusion

The investigators concluded that the accident occurred because of mismanagement by the Team Leader who failed to check that the parking area was safe.

## Recommendations

The investigators recommended that the Team Command group should be held responsible for ensuring that parking, store and rest areas are safe before using them. Also that the Team leader should be fully briefed about suspect areas around the working area, and that disciplinary action should be taken against the Group Leader.

The UN MAC said that there was "gross mismanagement" by the demining group leader who allowed vehicles to be parked in an unknown area, and an unknown path to be used for access to working area. "Serious disciplinary action" should be taken against him.

## Victim Report

<b>Victim number:</b> 174	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> dog-handler	<b>Fit for work:</b> no
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

**Summary of injuries:****INJURIES**

minor Eye

minor Face

**COMMENT**

Victim suffered severe compression trauma and was paralysed from the waist down. See medical report.

**Medical report**

Victim No.1's injuries were summarised at the time as "left eye, nose, lip, eyebrow and paralysis from waist down".

The insurers were informed on 4<sup>th</sup> December 1997 that the victim had suffered head injuries and was in a coma. On 9<sup>th</sup> February 1998 the insurers were told that the victim's injuries had resulted in paraplegia. A claim was submitted for multiple injuries and paralysis.

A doctor's letter stating that the victim's spinal cord was damaged in the accident was sent to the insurers on 23<sup>rd</sup> April 1998.

No record of compensation was found in June 1998.

**Victim Report**

**Victim number:** 175

**Name:** Name removed

**Age:**

**Gender:** Male

**Status:** dog-handler

**Fit for work:** yes

**Compensation:** not made available

**Time to hospital:** not recorded

**Protection issued:** Not recorded

**Protection used:** none

**Summary of injuries:**

minor Chest

minor Leg

severe Back

**COMMENT**

Victim suffered "spinal trauma". See medical report.

**Medical report**

Victim No.2's injuries were summarised at the time as "left leg, back and chest".

The insurers were informed on 4<sup>th</sup> December 1997 that the victim had suffered severe facial injury and spinal trauma.

A disability claim was submitted on 6<sup>th</sup> January 1998 stating that the victim had suffered a blunt trauma to back and was away from work until 31<sup>st</sup> December 1997.

No record of compensation was found in June 1998.

### **Victim Report**

<b>Victim number:</b> 176	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> dog-handler	<b>Fit for work:</b> presumed
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

#### **Summary of injuries:**

minor Head

COMMENT

See medical report.

#### **Medical report**

Victim No.3's injuries were summarised at the time as "head and forehead".

The insurers were informed on 4<sup>th</sup> December 1997 that the victim had suffered minor injuries.

No record of compensation was found in June 1998.

### **Victim Report**

<b>Victim number:</b> 177	<b>Name:</b> Name removed
<b>Age:</b>	<b>Gender:</b> Male
<b>Status:</b> driver	<b>Fit for work:</b> presumed
<b>Compensation:</b> not made available	<b>Time to hospital:</b> not recorded
<b>Protection issued:</b> Not recorded	<b>Protection used:</b> none

#### **Summary of injuries:**

minor Face

minor Leg

COMMENT

See medical report.

#### **Medical report**

Victim No.4's injuries were summarised at the time as "right leg and abrasion on forehead".

The insurers were informed on 4<sup>th</sup> December 1997 that the victim had suffered minor injuries.

No record of compensation was found in June 1998.

## **Analysis**

The primary cause of this accident is listed as a "*Management control inadequacy*" because although the field supervisors failed to ensure that the parking area was safe, their managers failed to tell them that the area was a former minefield - or possibly a former cleared area.

The poor co-ordination between survey and clearance teams, regional control centre and field workers represents a significant management failing.

The agency that was used to make investigations for the UN MAC (based in Pakistan) at this time was frequently constrained by lack of funds, staff and transport. At times their movement was constrained by safety concerns. As a result, investigations were frequently delayed by weeks, meaning that an assessment of the site at the time of the accident was impossible.

### 2000 MAC manager comment

..... It is ... primarily the responsibility of Team Leaders to ensure that he/she adequately reconnoitres the minefield task and identifies safe/cleared/etc areas before commencing physical work.